State of California—Health and Human Services Agency
Department of Health Care Services

David Maxwell-Jolly
Director

ARNOLD SCHWARZENEGGER
Governor

QUALITY ASSURANCE FEE FOR THE 2010-11 RATE YEAR

November 16, 2010

Dear Administrator:

This letter provides updated information concerning the Quality Assurance Fee (QAF) assessed for each skilled nursing facility for the rate year, August 1, 2010 to July 31, 2011. *California Health and Safety Code,* Sections 1324.20 – 1324.30 and *Welfare and Institutions Code,* Section 14105.06, authorize the Department of Health Care Services (DHCS) to collect a QAF from all non-exempt Free-Standing Skilled Nursing Facilities and Free-Standing Skilled Adult Sub Acute Nursing Facility Level-Bs (FS/NF-Bs). Pursuant to proposed statutory changes (Statutes 2010), the DHCS will be authorized to assess a QAF on multilevel facilities (MLRCs). The purpose of this fee is to enhance federal financial participation in the Medi-Cal program, and to provide additional reimbursement and support for quality improvement efforts in licensed FS/NF-Bs that provide services for the Medi-Cal program.

Effective August 1, 2010, for the rate year 2010-11, DHCS will begin collecting the QAF authorized by the legislature on all SF/NF-Bs, subject to the fee. DHCS will collect the following on a monthly basis:

FS/NF with less than 100,000 total annual resident days – $13.08 per resident day.
FS/NF with equal to or greater than 100,000 total annual resident days – $11.93 per resident day.

DHCS will send quarterly notices to each facility with three monthly payment forms with the current QAF rate, the payment due date, and the address to mail all payments and forms. Payments are due on or before the last day of the month following the month for which the fee was imposed.

Information about the Long Term Care Reimbursement including provider bulletins is available on the DHCS web site, http://www.dhcs.ca.gov/services/medi-cal/Pages/LTCAB1629.aspx.
Information about the QAF program and QAF payment forms are available at the DHCS website, http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx.

If you have any questions, please contact the Skilled Nursing Facility Quality Assurance Fee Program Coordinator by e-mail at ab1629@dhcs.ca.gov, or by phone at (916) 650-0490.

Sincerely,

Deanna Alvarez, Chief
Quality Assurance Fee Unit

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 - 2011 (FY)
Payment Invoice for AUGUST 1, 2010 to AUGUST 31, 2010

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Office of Statewide Health Planning and Development Number:

National Provider Identifier:

Due Date:

Amount Remitted: $_____

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
5650	000	00	H	125600	31	85214	A10	0001

Total Resident Days_____ Multiply by $13.08 = Amount Due _____

Original Signature _____ Date _____

Print Name _____ Phone Number _____ E-Mail _____

PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions:

Total Resident Days - Enter the *Total Resident Days* for the month that is listed on the payment invoice. Resident days are the number of days in which a patient resides at the skilled nursing facility. This includes, but is not limited to Bed Hold Days, Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Medicare Advantage, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity, and Hospice.

Amount Due - Multiply the *Total Resident Days* by $13.08 and enter that amount in the space provided for the *Amount Due*.

Amount Remitted - Enter the amount of the check or money order you are sending with this payment invoice. This amount should be the same amount as the *Amount Due*.

Original Signature - Sign in the space provided. Please use ink.

Date - Enter the date you completed this payment invoice.

Phone Number/E-Mail - Enter your area code, daytime phone number, and E-Mail address.

Payment invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx.

Please submit this completed payment invoice along with the *Amount Due* to the address above. All checks or money orders must be made out to the Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the due date above. Failure to make the complete payment on time may result in penalties and/or a delay in license renewal.

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 - 2011 (FY)
Payment Invoice for SEPTEMBER 1, 2010 to SEPTEMBER 30, 2010

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Office of Statewide Health Planning and Development Number:

National Provider Identifier:

Due Date:

Amount Remitted: $_____

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
5650	000	00	H	125600	31	85214	A10	0001

Total Resident Days_____ Multiply by $13.08 = Amount Due _____

Original Signature _____ Date _____

Print Name _____ Phone Number _____ E-Mail _____

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Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 - 2011 (FY)
Payment Invoice for OCTOBER 1, 2010 to OCTOBER 31, 2010

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Office of Statewide Health Planning and Development Number:

National Provider Identifier:

Due Date:

Amount Remitted: $_____

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
5650	000	00	H	125600	31	85214	A10	0001

Total Resident Days_____ Multiply by $13.08 = Amount Due _____

Original Signature _____ Date _____

Print Name _____ Phone Number _____ E-Mail _____

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Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 – 2011 (FY) Payment Invoice for November 1, 2010 to November 30, 2010

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Facility Name: _____

Address: _____

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Office of Statewide Health Planning and Development Number: _____

National Provider Identifier:

_____

Due Date: 12/31/2010

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
5650	000	00	H	125600	31	85214	A10	0001

Total Resident Days_____ Multiply by $13.08 = Amount Due _____

Original Signature _____ Date _____

Print Name _____ Phone Number _____ E-Mail _____

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Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 – 2011 (FY) Payment Invoice for December 1, 2010 to December 31, 2010

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Facility Name: _____

Address: _____

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Office of Statewide Health Planning and Development Number: _____

National Provider Identifier:

_____

Due Date: 1/**31/2011**

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
5650	000	00	H	125600	31	85214	A10	0001

Total Resident Days_____ Multiply by $13.08 = Amount Due _____

Original Signature _____ Date _____

Print Name _____ Phone Number _____ E-Mail _____

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Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 – 2011 (FY) Payment Invoice for January 1, 2011 to January 31, 2011

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Facility Name: _____

Address: _____

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Office of Statewide Health Planning and Development Number: _____

National Provider Identifier: _____

Due Date: **2/28/2011**

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
5650	000	00	H	125600	31	85214	A10	0001

Total Resident Days_____ Multiply by $13.08 = Amount Due _____

Original Signature _____ Date _____

Print Name _____ Phone Number _____ E-Mail _____

PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

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Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 – 2011 (FY) Payment Invoice for February 1, 2011 to February 28, 2011

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Facility Name: _____

Address: _____

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Office of Statewide Health Planning and Development Number: _____

National Provider Identifier:

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Due Date: 03/31/2011

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
5650	000	00	H	125600	31	85214	A10	0001

Total Resident Days_____ Multiply by $13.08 = Amount Due _____

Original Signature _____ Date _____

Print Name _____ Phone Number _____ E-Mail _____

PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

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Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 – 2011 (FY) Payment Invoice for March 1, 2011 to March 31, 2011

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Facility Name: _____

Address: _____

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Office of Statewide Health Planning and Development Number: _____

National Provider Identifier:

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Due Date: 4/**30/2011**

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
5650	000	00	H	125600	31	85214	A10	0001

Total Resident Days_____ Multiply by $13.08 = Amount Due _____

Original Signature _____ Date _____

Print Name _____ Phone Number _____ E-Mail _____

PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

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Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 – 2011 (FY) Payment Invoice for April 1, 2011 to April 30, 2011

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Facility Name: _____

Address: _____

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Office of Statewide Health Planning and Development Number: _____

National Provider Identifier: _____

Due Date: **5/31/2011**

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
5650	000	00	H	125600	31	85214	A10	0001

Total Resident Days_____ Multiply by $13.08 = Amount Due _____

Original Signature _____ Date _____

Print Name _____ Phone Number _____ E-Mail _____

PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

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Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 – 2011 (FY) Payment Invoice for May 1, 2011 to May 31, 2011

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Facility Name: _____

Address: _____

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_____

Office of Statewide Health Planning and Development Number: _____

National Provider Identifier:

_____

Due Date: 06/30/2011

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
5650	000	00	H	125600	31	85214	A10	0001

Total Resident Days_____ Multiply by $13.08 = Amount Due _____

Original Signature _____ Date _____

Print Name _____ Phone Number _____ E-Mail _____

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Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 – 2011 (FY) Payment Invoice for June 1, 2011 to June 30, 2011

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Facility Name: _____

Address: _____

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Office of Statewide Health Planning and Development Number: _____

National Provider Identifier:

_____

Due Date: 7/**30/2011**

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
5650	000	00	H	125600	31	85214	A10	0001

Total Resident Days_____ Multiply by $13.08 = Amount Due _____

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Print Name _____ Phone Number _____ E-Mail _____

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Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 – 2011 (FY) Payment Invoice for July 1, 2011 to July 31, 2011

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Facility Name: _____

Address: _____

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Office of Statewide Health Planning and Development Number: _____

National Provider Identifier:

_____

Due Date: **8/31/2011**

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
5650	000	00	H	125600	31	85214	A10	0001

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Total Resident Days - Enter the *Total Resident Days* for the month that is listed on the payment invoice. Resident days are the number of days in which a patient resides at the skilled nursing facility. This includes, but is not limited to Bed Hold Days, Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity, and Hospice.

Amount Due - Multiply the *Total Resident Days* by $13.08 and enter that amount in the space provided for the *Amount Due*.

Amount Remitted - Enter the amount of the check or money order you are sending with this payment invoice. This amount should be the same amount as the *Amount Due*.

Original Signature - Sign in the space provided. Please use ink.

Date - Enter the date you completed this payment invoice.

Phone Number/E-Mail - Enter your area code, daytime phone number, and E-Mail address.

Payment invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx.

Please submit this completed payment invoice along with the *Amount Due* to the address above. All checks or money orders must be made out to the Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the due date above. Failure to make the complete payment on time may result in penalties and/or a delay in license renewal.